Chartered Society of Physiotherapy

The new NHS commissioning structure

In July 2010, the Department of Health published the NHS White Paper *Equity and excellence: Liberating the NHS* which set out the Government's proposals for reforming the health and social care services in England. This set out the Government's proposals to reform the health service around the principles of '*no decision about me, without me'*, putting clinicians at the heart of decision-making, and placing the emphasis on delivering better health outcomes.

Developed on behalf of the Chartered Society of Physiotherapy (CSP), this briefing sets out the new commissioning structure, including the role of the new commissioning bodies, clinical senates and clinical networks.

1. Department of Health

The Department of Health will essentially oversee three services:

- **The NHS Commissioning Board**: responsible for the commissioning of NHS services but with no power to intervene in the provision of NHS care (with the exception of high security mental health institutions)
- **Public Health England:** responsible for vaccination and screening programmes, the management of public health emergencies, health improvement, as well as public health research, analysis and evaluation
- **The social care service:** details of which will be confirmed with a forthcoming white paper

Each service will have different performance management mechanisms, budgeting processes and lines of accountability. This is a major change from previous arrangements.

2. The role of the NHS Commissioning Board

While the Secretary of State *"will retain ultimate accountability for securing the provision of services"*, the Board will be responsible and accountable to the Secretary of State for the outcomes achieved and delivered by the NHS[1].

In carrying out its functions, the Board will receive a short mandate from the Secretary of State. This will be subject to formal consultation and parliamentary scrutiny, and is likely to cover a three year period, and be updated annually. This mandate will set out the totality of what the Government expects from the Board on behalf of the taxpayer for that period. The Secretary of State may impose additional performance requirements on the Board in-year but will have to report to Parliament to explain why.

The Board will have overall responsibility for a budget of approximately £80 billion, of which £60 billion will be allocated directly to local NHS commissioners. The Board will directly commission a range of services including primary care and specialised services. It will also work alongside Public Health England to deliver broader improvements to public health outcomes.

Overall, the Board will be in place to help drive improvements in patient outcomes and in ensuring a comprehensive health service across the country. The Board will also be a national champion of the NHS Constitution through greater choice and information for patients.

2.1 Main functions of the NHS Commissioning Board

The Board's main functions will be:

- Providing national leadership on commissioning for quality improvement, including:
  - setting commissioning guidelines on the basis of clinically approved quality standards developed with the advice of NICE in a way that promotes joint working across health, public health and social care
  - designing model contracts for local commissioners to adapt and use with providers
  - designing the structure of the tariff and other financial incentives (Monitor will set tariff levels)
  - hosting clinical networks and clinical senates
  - setting standards for the quality of NHS commissioning and procurement
  - making available accessible information on commissioner performance
  - tackling inequalities in outcomes of healthcare
  - spreading good practice

- Promoting and extending public and patient involvement and choice, including:
  - championing greater involvement of patients and carers in decision-making and managing their own care, working with commissioners and local authorities
  - promoting personalisation and extending patient choice including personal health budgets
  - commissioning information requirements for choice and for accountability, including through patient-reported measures

- Ensuring the development of clinical commissioning groups, including:
  - authorising clinical commissioning groups to take responsibility of local commissioning
  - supporting and developing the establishment and maintenance of an effective and comprehensive system of clinical commissioning groups
  - holding commissioning groups to account for delivering outcomes and financial performance

- Commissioning certain services that cannot solely be commissioned by commissioning groups, in accordance with the Secretary of State's designation, including:
  - general practice, dentistry, community pharmacy and primary ophthalmic services
  - national specialised services and regional specialised services set out in the Specialised Services National Definitions Set

- Allocating and accounting for NHS resources, including:
  - allocating NHS revenue resources to commissioning groups on the basis of seeking to secure equivalent access to NHS services relative to the burden of disease and disability
  - managing an overall NHS commissioner revenue limit, for which it will be accountable to the Department of Health

- promoting productivity through better commissioning

The Board will also be responsible for commissioning local services in those areas which are not covered by a clinical commissioning group.

2. 2 Structure of the NHS Commissioning Board

The NHS Commissioning Board will be based at Quarry House in Leeds, as well as having a smaller central London office. In December 2010, Andrew Lansley MP confirmed that Sir David Nicholson would be the Chief Executive of the Board. The Government has also confirmed that the Board will have a Medical Director and Chief Nursing Officer as members[2], although no confirmation has yet emerged in regards to a lead allied health professional.

To support it in its functions, the NHS Commissioning Board is likely to have a staff of around 3,500. Of these *"approximately two thirds will be deployed locally within the "field force" managing relationships with clinical commissioning groups and performing direct commissioning and other associated functions"*[3].

In *Developing the NHS Commissioning Board*, the Department of Health confirmed that the NHS Commissioning Board will be structured around the five domains in *The NHS Outcomes Framework 2011/12*[4]. These are:

- Domain 1: Preventing people from dying prematurely
- Domain 2: Enhancing quality of life for people with long-term conditions
- Domain 3: Helping people to recover from episodes of ill health or following injury
- Domain 4: Ensuring that people have a positive experience of care
- Domain 5: Treating and caring for people in a safe environment and protecting them from avoidable harm

National professional leads will be appointed for each outcome area who will report to a Medical Director and Nursing Director. The Board will also have a number of supporting functions organised under directors at national level. The purpose of these functions will be to support the achievement of better outcomes.

The Department of Health has also confirmed that the Board will include: "*Dedicated professional advice and leadership for more specific outcome areas within the five domains, for example cancer, diabetes or infection control*"[5].

2.3 Local and regional support

Following the listening exercise, the Department of Health confirmed that the existing primary care trust clusters would remain beyond April 2013 as "*local arms of the NHS Commissioning Board"* [6].
The Department has yet to confirm the details of how these local teams will be organised, although they are likely to reflect the current PCT cluster arrangements.

Nonetheless, these local teams will be responsible for "*providing development support, monitoring finance and performance, measuring outcomes and providing information and more general communication"* to local clinical commissioning groups[7].

It has been confirmed there will also be "*commissioning sectors*" reflecting the four strategic health authority (SHA) clusters which are currently emerging. The four clusters will cover:

- NHS London
- NHS North of England (comprising of North West, North East and Yorkshire and The Humber SHAs)
- NHS Midlands and East (West Midlands, East Midlands and East of England SHAs)
- NHS South of England (South West, South Central and South East Coast SHAs)

The functions of these commissioning sectors would include[8]:

- Leadership of a number of more local teams overseeing the Board's relationships with clinical commissioning groups, its direct commissioning functions, and its relationships with other partners such as local government. These teams could operate initially within areas covered by PCT clusters
- Hosting a specialised commissioning team, overseeing arrangements across the sector
- Appointing key function leads which the Board will need to carry out its duties at a more local level, including finance and professional leadership
- Being organised under an overall lead to whom these functional leads would report and who would in turn report to the National Director for Finance, Performance and Operations

2.4 The timescale for establishing the NHS Commissioning Board

The NHS Commissioning Board will be established in shadow form as a 'special health authority' in October 2011.

Subject to the passing of the Health and Social Care Bill the Board will be established formally as an independent body by October 2012. It will then "*start to authorise clinical commissioning groups and carry out preparatory functions*"[9] ahead of taking full responsibilities from April 2013.

Other key milestones in the establishment of the Board include:

- July 2011 - Arrangements for senior and priority appointments published
- Summer/Autumn 2011 - Further details published about the proposed operating model of the Board including its key processes
- Autumn 2011 - Further publication setting out proposed structure for the Board in more detail
- October 2011 - October 2012: Shadow running phase and further recruitment of staff
- 2012 - further information published about the process for staff appointments

3. Clinical commissioning groups

The Department of Health has been keen to stress that it will be for clinical commissioning groups to determine their overall structure. However, the Department of Health has confirmed that, following the NHS listening exercise, each clinical commissioning group will have:

- Governing bodies made up of, as well as GPs, at least one registered nurse and a doctor who is a secondary care specialist (although they must have no conflict of interest in relation to the clinical commissioning group's responsibilities)

Details of these boards will be publically available, with an appointed chair, and will be key stakeholders for local CSP members when seeking to influence commissioning decisions. These governing bodies will be required to meet in public and will be responsible for:

- Working with their respective health and wellbeing board in the development of the joint strategic needs assessment (JSNA) and the joint health and wellbeing strategy (JHWS)
- Preparing and publishing a commissioning plan before the start of each financial year

Within this and more broadly, clinical commissioning groups will be responsible for:

- Commissioning the great majority of NHS services for patients
- Managing their commissioning budgets and using these resources to improve healthcare and health outcomes
- Utilising the freedom to decide what commissioning activities they undertake for themselves and for what activities (such as demographic analysis, contract negotiation, performance monitoring and aspects of financial management) they may choose to buy in support from external organisations, including local authorities, private and voluntary sector bodies
- Receiving a maximum management allowance to reflect the costs associated with commissioning, with a premium for achieving high quality outcomes and for financial performance
- Having a duty to promote equalities and to work in partnership with local authorities, for instance in relation to health and adult social care, early years services, public health, safeguarding and the wellbeing of local populations
- Having a duty of public and patient involvement, and so will need to engage patients and the public in their neighbourhoods in the commissioning process

Clinical commissioning groups will not be responsible for commissioning services that GPs themselves provide or the other family health services, dentistry, community pharmacy and primary ophthalmic services.

4. Local authorities

With the abolition of PCTs in 2013, local authorities will now take on a number of new commissioning functions, including:

- Establishing health and wellbeing boards which will support the integration of local NHS, social care and public health services and approve commissioning plans
- Leading JSNA and JHWS to promote collaboration on local commissioning plans, including by supporting joint commissioning arrangements where appropriate
- Jointly appointing the Director of Public Health with Public Health England and overseeing the ring-fenced public health budget to deliver health improvements to the local community

Based on the Public Health Outcomes Framework, the Secretary of State through Public Health England will set local authorities national objectives for improving population health outcomes. It will be for local authorities to determine how best to deliver these improvements, including through working with local NHS commissioners.

5. Health and wellbeing boards

As set out above, all upper tier and unitary local authorities will be required to establish health and wellbeing boards. These boards will be responsible for leading on the development of the JSNA and JHWS for each locality, and in promoting integration across health, public health and social care services.

In terms of structure, health and wellbeing boards will be required to include:

- one local authority councillor
- the director of adult social services for the local authority
- the director of children's services for the local authority
- the director of public health for the local authority
- a representative of the local healthwatch organisation
- a representative of each relevant clinical commissioning group
- other persons, or representatives, as the local authority feels appropriate (including allied health professionals)

A representative of the NHS Commissioning Board will also sit on the health and wellbeing board when it is drawing up its JHWS and JSNA. A key power of health and wellbeing boards will be to "*refer back local commissioning plans that are not in line with the health and wellbeing strategy"* to the NHS Commissioning Board.

For CSP members, it will be important to engage with these boards and to raise awareness of the important role physiotherapy services can play in improving patient outcomes – particularly while these boards develop their JHWS.

6. Clinical senates

In its response to the NHS Future Forum's report, the Government confirmed the establishment of new 'clinical senates' in each area of the country in order to ensure local commissioning groups have sufficient expert advice and support available to them when developing and delivering local commissioning plans. The establishment of senates followed criticism from professional bodies that reforms set out in the Health and Social Care Bill did not include the full range of clinicians in the commissioning of services.

Clinical senates will be made up of doctors, nurses and other professionals – including allied health professionals – and will give advice to commissioners which they will be expected to follow. Senates will also be expected to include public health and social care specialists in order to facilitate the integration of services. The Department of Health has also said that senates will have a role in potential service reconfiguration and in the authorisation of clinical commissioning groups.

In terms of structure, no specific guidance or details have yet to be made available. However, we can expect that:

- There will be between 14 and 20 clinical senates covering the country as a whole
- Clinical senates will include representatives from the local clinical networks for a specific disease areas or conditions

- Clinical senates will have a support and advisory role rather than being specifically responsible for redesigning services[10]

Although the Department has confirmed that guidance will be emerging shortly, these bodies will be important stakeholders when CSP members are looking to advise how the patient pathway and services can best be redesigned to deliver better clinical outcomes. They will not, however, be statutory bodies and will have no specific statutory duties.

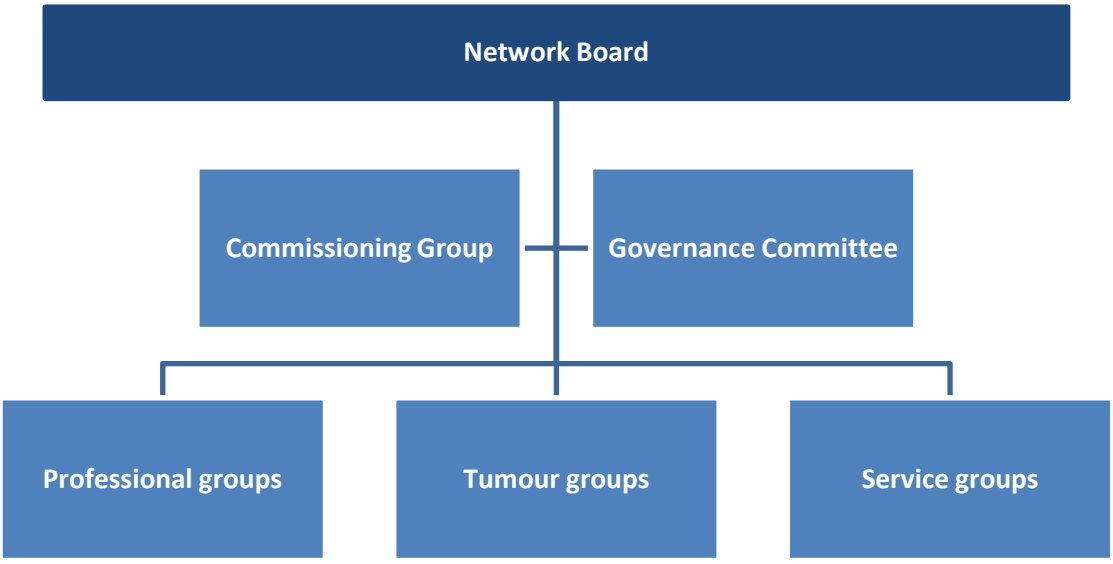
7. Clinical networks

Existing clinical networks will be strengthened and will support clinical commissioning groups on specific areas of care, such as cancer. They too will be hosted within the NHS Commissioning Board. The Government confirmed plans to expand networks so they "*cover many more areas of specialist care*"[11]. It is expected that there will be three main types of networks:

- very specialist, eg neonatal intensive care
- specialist but more generic, eg cancer
- higher level generic, eg acute care

As with clinical senates, these networks will not be statutory bodies and will, therefore, have no legal duties or designated structure. However, the Department of Health has confirmed its intention to structure clinical networks in a similar way to cancer networks.

Figure 1: NHS Pan Birmingham Cancer Network organisational structure[12]



This would involve bringing together:

- Providers of specific disease and condition areas (bodies which deliver services to patients)

- Commissioners of specific disease and condition areas (bodies which plan, purchase and monitor services for patients)
- Users of services and relevant healthcare professionals

Providers and commissioners are typically represented by their chief executives or a nominated executive who reports to the network's board, which is split into a number of key groups and committees. Figure 1 sets out an example of NHS Pan Birmingham Cancer Network's organisation or structure.

8. Care Quality Commission

In relation to the NHS, the CQC's responsibilities will include:

- Licensing on the basis of essential safety and quality requirements. Services will be jointly licenced by the CQC and Monitor. Where services fail to meet these essential levels, providers will be subject to enforcement action, including the possibility of fines and suspension of services
- Inspecting providers against the essential levels of safety and quality. Inspection will be targeted and risk-based
- Using feedback from complaints, HealthWatch, GP consortia and the NHS Commissioning Board to inform inspections

9. Monitor

The post-reform Monitor will bear little resemblance to the organisation that currently exists. It will be the economic regulator for the health and social care sectors, performing three key functions:

- Promoting integration and ensuring that it works effectively in the interests of patients
- Regulating prices, setting efficient prices, or maximum prices, for NHS-funded services, in order to promote fair competition and drive productivity
- Supporting continuity of services by defining regulated services that will be subject to special licence conditions and controls, including risk sharing and special funding arrangements

Sitting within Monitor will be the Co-operation and Competition Panel which will maintain and oversee the existing competition rules for the NHS, as set by the previous Government.

10. HealthWatch

At a national level, HealthWatch will be established as part of the CQC to ensure that the voice of patients and the public is heard within the regulatory system. It will:

- Provide leadership, advice and support to local HealthWatch, and will be able to provide advocacy services on their behalf if the local authority wishes
- Provide advice to the Health and Social Care Information Centre on the information which would be of most use to patients to facilitate their choices about their care
- Provide advice to the NHS Commissioning Board, Monitor and the Secretary of State
- Have the powers to propose CQC investigations of poor services

At a local level, HealthWatch organisations will be commissioned by local authorities. Essentially, they will take the form of what are currently known as Local Involvement Networks (LINks). Local HealthWatch organisations will:

- Ensure that the views and feedback from patients and carers are an integral part of local commissioning across health and social care
- Provide advocacy and support services, supporting individuals who want to make a complaint
- Provide a source of intelligence for national HealthWatch and will be able to report concerns about the quality of providers, independently of the local authority

11. National Institute for Clinical Excellence

NICE will continue to be responsible for providing national guidance on the promotion of good health and the prevention and treatment of ill health, as well as making recommendations to the NHS on new and existing medicines, treatments and procedure, and treating and caring for people with specific diseases and conditions. In the new NHS structure, NICE will also be responsible for developing a suite of 150 quality standards which will reflect good patient care for specific disease areas.

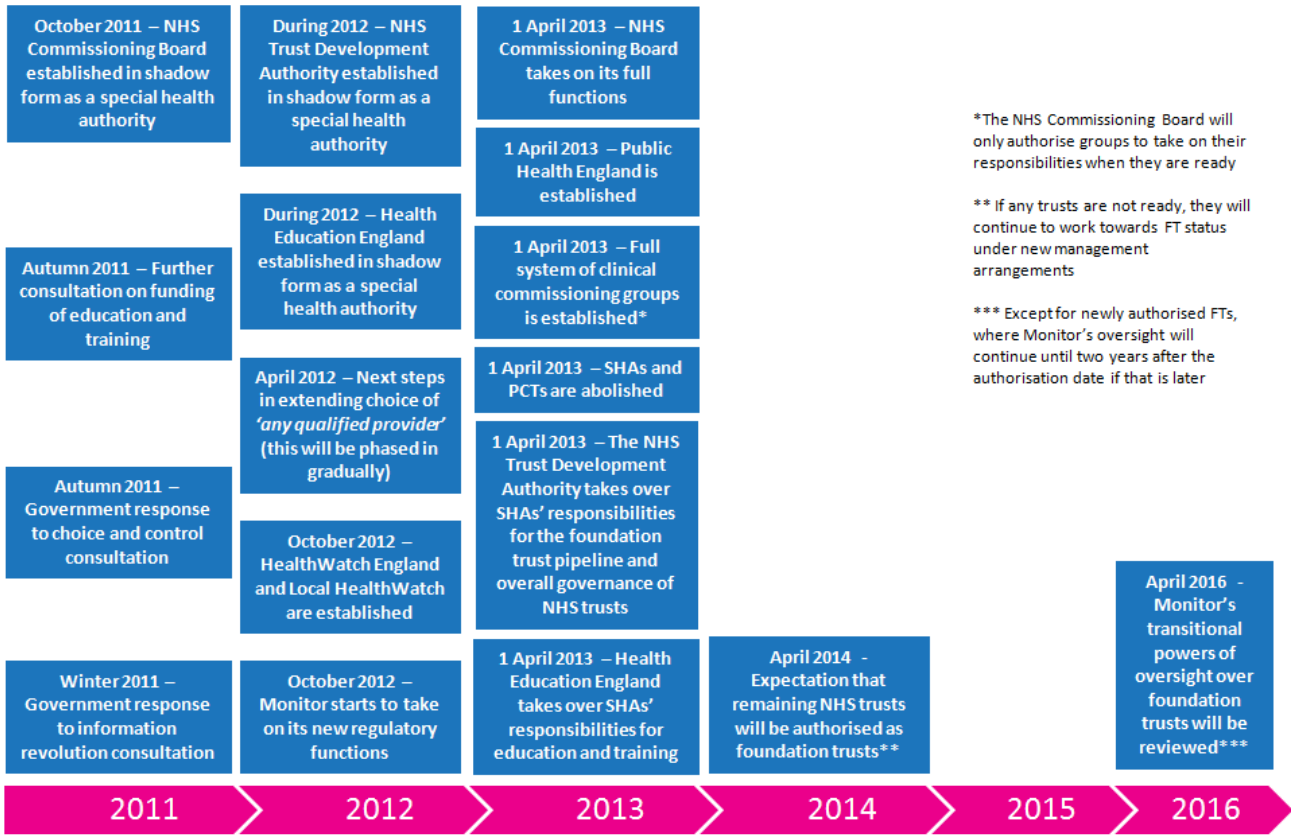
12. Providers

The Department of Health and the NHS Commissioning Board will not have a role in intervening in the activities of service providers, other than through discharging commissioning functions. This will result in greater autonomy for NHS providers. In order to achieve this:

- The separation of commissioning from provision was completed in April 2011
- All NHS providers will become foundation trusts, with a new unit in the Department of Health driving progress - although progress to delivering this will remain varied
- An 'any willing provider' approach will be adopted for community services, with all community services being provided by foundation trusts or other types of provider (as opposed to PCT provider arms)
- Some of the constraints on foundation trusts will be lifted. This is likely to include:
  - removing foundation trusts from the public sector balance sheet, although this will be subject to Office of National Statistics approval
  - changing the rules on the composition of trusts to enable employee-only leadership
  - abolishing the cap on the amount of income foundation trusts may earn from other sources
  - enabling foundation trusts to merge more easily

- In future, all individual employers will have the right to determine pay for their own staff

Annex 1: Key milestones



[1] Department of Health, *Government response to the NHS Future Forum report*, June 2011
[2] Department of Health, *Government response to the NHS Future Forum report*, June 2011
[3] Department of Health, *Developing the NHS Commissioning Board*, July 2011
[4] Department of Health, *Developing the NHS Commissioning Board*, July 2011
[5] Department of Health, *Developing the NHS Commissioning Board*, July 2011
[6] Department of Health, *Government response to the NHS Future Forum report*, June 2011
[7] Department of Health, *Developing the NHS Commissioning Board*, July 2011
[8] Department of Health, *Developing the NHS Commissioning Board*, July 2011
[9] Department of Health, *Government response to the NHS Future Forum report*, June 2011
[10] GP Online, *Clinical senate influence on commissioning groups to be diluted, predicts NHS Alliance*, 30 August 2011
[11] Department of Health, *Government response to the NHS Future Forum report*, June 2011
[12] NHS Pan Birmingham Cancer Network, *Introduction: How we work*. Accessed 30 August 2011. Available here: http://www.birminghamcancer.nhs.uk/about/intro